NOTIFICATION OF INDIVIDUAL'S DEATH

State Form 51685 (R2 / 7-04) / BQIS 0009

(*Type of print all information. When attaching additional sheets, clearly indicate which answer is being continued.*)

Family and Social Services Administration
Division of Disability, Aging and Rehabilitation Services
Mortality Review Committee

This document contains confidential medical information and is not subject to disclosure as a public record.

To: Mortality Review Committee
Bureau of Quality Improvement Services
402 West Washington Street
P.O. Box 7083
IGCS, Room W451
Indianapolis, IN 46207-7083
Fax: Lynn Underwood (317) 234-2225
Telephone: Lynn Underwood (317) 234-1146

From:

Agency
Address (*number and street*)
City, state, ZIP
Name of contact person (*name and title*)
Telephone number ( )

RESIDENT INFORMATION

Name of deceased		
Date of birth (*month, day, year*)	Age at death	Social Security number
Gender ☐ Male ☐ Female	Race	MRC number (*BDDS office use only*)
Address of deceased (*number and street, city, state, ZIP code*)		

PROGRAM INFORMATION

Service type (*check the appropriate service type*):

☐ A&D Waiver ☐ LP ICF/MR ☐ SL ☐ DD Waiver ☐ Nursing Home
☐ SGL ☐ Autism Waiver ☐ OBRA ☐ SDC ☐ SSW

Was the deceased ever a resident of a State Operated Facility?

☐ Yes ☐ No

If Yes, indicate facility and discharge date:

☐ Evansville State Hospital Date of discharge: _____
☐ Fort Wayne State Developmental Center Date of discharge: _____
☐ Muscatatuck State Developmental Center Date of discharge: _____
☐ Logansport State Hospital Date of discharge: _____
☐ Madison State Hospital Date of discharge: _____
☐ New Castle State Developmental Center Date of discharge: _____

REPORTING CONTACT VERIFICATION

Date of this report

CONTACT	DATE	TIME	NAME OF PERSON CONTACTED	HOW NOTIFIED	NOTIFIED BY WHOM *
BDDS (*required*)					
APS (*required*)					
Law Enforcement					
Case Manager					
Legal Guardian					

REPORTING CONTACT VERIFICATION (*continued*)

Contact information for individual(s) listed on first page.

Name of legal guardian	Relationship
Address (*number and street, city, state, ZIP code*)	
Case manager	Case manager's agency
Case manager address (*number and street, city, state, ZIP code*)	
Law enforcement	Law enforcement agency
Law enforcement address (*number and street, city, state, ZIP code*)	

INFORMATION REGARDING DEATH

1) Date of death (*month, day, year*)	2) Day of death	3) Time of death ☐ AM ☐ PM

4) Address where death occurred (*number and street, city, state, ZIP code*)

5) Type of setting where death occurred

6) Name of setting where death occurred (*if applicable*)

7) Primary cause of death

8) Secondary cause of death

Attach a copy of the Death Certificate. Death Certificates are available as a public record from the County Departments of Health.

9) Was a terminal illness diagnosed? ☐ Yes ☐ No	If Yes, date of diagnosis (*month, day, year*)

10) Identify terminal illness

11) Name, Position, and Relationship to client of person(s) present at the time of death:
(*if staff are listed, indicate which agency employs them. Attach an additional sheet if necessary*)

Name	Position	Relationship
Name	Position	Relationship
Name	Position	Relationship
Name	Position	Relationship
Name	Position	Relationship

12) Name of physician attending at time of death (*if different from primary physician*)	13) Telephone number of attending physician ( )

14) Address of attending physician (*number and street, city, state, ZIP code*)

15) Advance Directive / DNR / Code Status (*If Yes, attach a copy*) ☐ Yes ☐ No

16) Postmortem reports: Was an autopsy completed? ☐ Yes ☐ No If Yes, attach a copy of the autopsy report.	Is this death a coroner's case? ☐ Yes ☐ No If Yes, attach a copy of the coroner's report.

17) Autopsy authorized by whom/relationship

18) If no autopsy, indicate reason autopsy was not completed.

INFORMATION REGARDING DEATH (*continued*)

19) Name of primary physician

20) Telephone number of primary physician
( )

21) Address of primary physician (*number and street, city, state, ZIP code*)

22) Date of client's last medical appointment with primary physician (*month, day, year*)

23) Reason for last medical appointment

24) Was physician notified of patients illness prior to death?
☐ Yes ☐ No

25) Date of notification (*month, day, year*)

26) Name and title of person notifying physician

27) Have there been any incident reports, per BDDS reporting requirements, of abuse, neglect or injuries sustained by deceased (*for 12 months prior to death*)?
☐ Yes ☐ No

28) If Yes, attach a copy of the initial and follow-up report. Indicate the type of report and the date of reported and attach any copies of relevant information relating to incidents that occurred prior to the individuals death.

TYPE OF REPORT	DATE REPORTED

29) Was an internal investigation of the death conducted by your agency?
☐ Yes ☐ No

Attach a copy of the completed internal investigation report and supporting documentation. If not complete, submit the information upon completion of your investigation

30) Date completed (*month, day, year*)

Or, targeted date of completion (*month, day, year*)

31) If No, state the reason an internal investigation was not completed.

MOST CURRENT MEDICAL INFORMATION

32) Medications prescribed: Attach actual physician order sheet if available. (*Attach additional sheet if necessary*)

NAME OF MEDICATION	DOSAGE	FREQUENCY	DATE / TIME LAST GIVEN

33) Current diagnosis:

34) Past medical history: Submit a copy of the following information. Submit all information in chronological order from 12 months prior to and including date of death:
- Last physical completed by a physician,
- Physician consults / referrals,
- Diagnostic tests and lab tests completed.

HOSPITALIZATION INFORMATION

35) Was the client hospitalized in the 12 months, including time of death?

☐ Yes ☐ No

If Yes, list name of hospital date(s) of admission(s) / date(s) discharged / reason(s) for hospitalization. (A *discharge summary is required for each hospitalization listed.)*

Name of hospital	
Address of hospital (*number and street, city, state, ZIP code*)	
Date of admission (*month, day, year*)	Date of discharge (*month, day, year*)
Reason for hospitalization	
Physician's orders upon discharge	
Name of hospital	
Address of hospital (*number and street, city, state, ZIP code*)	
Date of admission (*month, day, year*)	Date of discharge (*month, day, year*)
Reason for hospitalization	
Physician's orders upon discharge	
Name of hospital	
Address of hospital (*number and street, city, state, ZIP code*)	
Date of admission (*month, day, year*)	Date of discharge (*month, day, year*)
Reason for hospitalization	
Physician's orders upon discharge	
Name of hospital	
Address of hospital (*number and street, city, state, ZIP code*)	
Date of admission (*month, day, year*)	Date of discharge (*month, day, year*)
Reason for hospitalization	
Physician's orders upon discharge	

ADDITIONAL INFORMATION

36) Provide copies of the following data from the individual's file for the 30-day period prior to their death. (*Submit in chronological order from date of death. If hospitalized prior to death, proved information for the last 30 days of services provided*)

- Nurses notes
- Progress notes
- Daily log sheets
- Training programs offered and staff attendance records
- Staffing schedules up to and including the date of the consumer's death

ADDITIONAL INFORMATION (*continued*)

37) Include a copy of the Individual Support Plan and Behavioral Plan.

38) Give any additional information that you feel is pertinent to this report. (*use additional sheets, if necessary*)

39) If any of the following apply to the individual, provide the information listed below or indicate that it does not apply: (*if any of the requested items were not maintained, provide a detailed response of all steps/actions taken to assure appropriate care was provided to the individual*)

a. If the individual experienced or had a diagnosis (*current or historical*) of Seizure Disorder:

- Neurological records
- Seizure records
- Policy for Neurology visits
- Medication history (*specifically note any changes in seizure or psychotropic medications*)
- Documentation of any constipation, input/output records, or elevated temperature

b. If the individual experienced choking and/or aspiration:

- Assessments utilized to develop the dining plan. (*indicate if a dysphasia assessment was completed*)
- Clarification of risk determination
- Chronological sequence of events and action during the incident (*step by step action taken as a result of the incident*)
- List of individual's present and their staff training records to specifically note if training had or had not been provided and current for First Aide and suctioning.
- Copy of dining plan including staff supervision and adaptive devices

c. If the individual experienced any Heart Related concerns:

- Cardiac assessments
- Complete medical history
- Chronological sequence of events and action during the incident (*step by step action taken as a result of the incident - including First Aide provided*)
- Policies and procedures on notification of Doctor of changes in medical condition
- Policy and procedures on reviewing care received during hospitalization
- Policy on the provision of CPR

d. If the individual experienced alleged or substantiated abuse and/or neglect in the 6 months prior to their death:

- Staff training curriculum
- Documentation that staff present for the 7 days prior to death have had training
- Policy on investigation to make a determination to substantiate abuse and/or neglect
- Policy on identification of high risk individual / abuse and/or neglect management, individualized plan to ensure the individual's safety and well-being
- Policy on staff to consumer interaction
- Documentation of training provided to staff on identification of stress of staff or possible signs of abuse (*indicate position of the staff and their level of integration with the individual's direct care staff*)
- Copies of all documents related to the internal investigation (*including reports regarding all allegations of abuse and/or neglect in the past six months*)

VERIFICATION OF INFORMATION INCLUDED IN THE REPORT

40) **(Must be verified by Agency's Executive Officer)**

I hereby verify that the information contained in this report is accurate.

Signature	Date verified (*month, day, year*)
Printed name and Title	Telephone number

This form is HIPAA compliant per the requirements of 45 CFR § 164.508(c).